and 33% were diabetic, and 61.9% were in NYHA class II, and 23.8% were in NYHA class III. The median of 6min walk test was 118m. The mean LVEF was 46% (40- 69). Hypertensive (44.4%) and Ischemic heart disease (17.46%) remain the two most frequent etiology. During a median follow up of 32 months, mortality was 16%. By univariable analysis, NHYA class; 6min walk distance; atrial fibrillation; right ventricular dysfunction and systolic pulmonary artery pressure (sPAP) were associated with an adverse prognosis.
In multivariable analysis, increasing age, NYHA class, and renal failure were predictors of adverse prognosis; beta-blockers treatment, increasing Hb and female sex were predictors of a better outcome.

Conclusion: As several studies, clinical and biological variables were more powerful predictors of outcome in HFPEF than echocardiographic variables which are recommended to identify diastolic function.

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History of breast cancer in women with acute myocardial infarction. Data from the RICO survey

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Background: Breast Cancer (BC) is the most frequent cancer, whereas CV diseases such as myocardial infarction (MI) are the leading cause of death. BC and MI share common major risk factors such as obesity. We aimed to analyse the characteristics of women with a history of BC in the setting of acute MI.

Patients and methods: Among the 2087 consecutive women included between 01/01/2001and 31/12/2009 in the French regional RICO survey database, 73 (3%) had a history of BC. Each woman with prior BC (n=73) was matched, with respect to age, with 5 women without prior BC (n=365).

Results: Women with prior BC were 74 (65-80) year old. Time from BC diagnosis to acute MI was 10 (3-16) years. Most BC had been treated by surgery and/or radiation therapy, and 37% had also received hormone therapy. CV risk factors (smoking, obesity), type of MI, acute management and in-hospital complications were similar for the 2 groups. Chronic statin use and admission blood lipids were also identical for the 2 groups. However, median admission CRP levels were lower in women with a history of BC (1.0(1.0–9.8) vs. 5.6 (2.8–13.6) mg/l, respectively, p<0.001). Strikingly, peak CK and troponin Ic levels, the latter of which reflects infarct size, were dramatically lower, by 40%, and 26 %, respectively, in the BC group (310 (136–777) vs. 501 (198-1324) UI/l, p=0.022 and 9.20 (3.33-19.55) vs. 12.36 (2.77-41.00) µg/l, p=0.166 respectively). By linear regression analysis, prior BC remains an independent predictor of reduced peak CK (B(SE)=-626.8(260), p=0.017), even when adjusted for potential confounders (anterior wall location, STEMI, multivessel disease, time to admission).

Conclusions: In women currently admitted for acute MI, a non-negligible proportion had prior BC. Women with prior BC had a similar risk profile and lipid levels to those in women without prior BC. However, they were characterized by a lower level of inflammation and smaller infarct size than their counterparts without BC. Further investigations are ongoing to determine whether hormone therapy such as oestrogen receptor modulators could account for the observed effects in this population.

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Pharmacological treatment of chronic heart failure in the region of Marrakech : where are we compared to the recommendations?

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Introduction: heart failure (HF) is a frequent pathology which profited from important therapeutic progress. The respect of the international recommendations is essential in order to optimize its managment.

The objective of this study was to evaluate the adequacy of our practice with the international recommendations concerning the pharmacologic management of chronic HF.

Patients and methods: It is about an observational prospective study over six months including of the patients followed in cardiologic consultation for chronic HF. The data collected the demographic elements(old, sex…) elements concerning HF (class NYHA, etiology, number of decompensation during the previous year…) and data concerning the pharmacological treatment prescribed (molecules, doses, tolerance of the treatment, the control of the side effects by the electric and biological complementary examinations.). The adequacy of this treatment compared to the French recommendations of 2007 was evaluated by a cardiologist senior who was not responsible for the follow-up of the patient.

Results: Hundred two patients were included (42 women and 60 men with a sex ratio of 1.15). The Middle Age was of 56.9 +-26.1 years. All the patients (100%) were treated by the diuretic,78% of the cases were under converting enzyme inhibitors (ACE),85% of the patients were under bétabloquants (BB), 75% of the patients were put under the triad diuretic- ACE- BB. The digitaliques had been prescribed at 21,4% of the patients who presented a chronic cardiac failure in arrhythmia. The recommended target doses was noted in 35,7% for ACE inhibitors, 25% for BB and 14,3 for diuretics.

Conclusion: Our study reveals an insufficient adequacy of our practice with the international recommendations. Improving the management of Hf based on the knowledge of the various therapeutic classes recommended in the HF and their target doses.The creation of a unit of HF seems essential then.

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Cardiac sarcoidosis : therapeutic management and prognostic factors from a cohort of 130 patients.

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The diagnosis of cardiac sarcoidosis (CS) (56 female-74 male; 73 White-36 Black; age at CS: 40.5 ± 11.7 years) was defined by clinical signs (20%) and/or evidence of at least two procedures abnormalities: ECG (64%), echocardiography (71%), Magnetic Resonance Imaging (MRI) (58%) and myocardial scintigraphy (72%). With a 54 month-median follow-up, 124 patients were evaluable. The first line therapy was steroids alone in 57% of cases, steroids with immunosuppressive (IS) drug in 43%. A relapse of the CS was noted in 35 patients, a median time of 27 months.

The RR of relapsing at any time was 3.1 times higher in Black (P=0.008) and 4 times more when baseline abnormal myocardial MRI (P=0.008). A recovery was achieved by 91 patients (73%), a stabilisation in 23% and 3% worsened. The relative risk (RR) of not recovering at any time was 5.4 times higher in patients who had a steroids treatment duration of less than 24 months (P < 0.0001), 2.4 times higher in patients with a nervous system involvement (P = 0.018) and 3.7 times higher in those who received a first line therapy with weekly methotrexate (P = 0.009). It was 21 times lower in patients who received monthly bolus of cyclophosphamide (CY) (P=0.004).

Death occurred in 13 patients (10%), related to CS in two patients. The 5-year survival rate was 91%. CS had a good prognosis under steroids alone or associated with an IS drug with a global recovery rate of 73% and a 5-year Survival rate of 91%. The risk of not recovering was associated with a steroids treatment duration of less than 24 months, and the use of a methotrexate first line therapy whereas CY was associated with a better prognosis. The identified independent risk-factors for relapsing were Black origin and a baseline abnormal cardiac MRI. This cohort demonstrates the need of maintaining a careful clinical and paraclinical follow-up of patients with a cardiac sarcoidosis with a more than 24-month steroids therapy.